DOCUMENT RESUME

ED 141 026 RC 009 962

TITLE	AISOM (The American Indian School of Medicine), March 1977.
INSTITUTION	American Indian School of Medicine, Shiprock, N. Mex.
PUB DATE	Mar 77
NOTE	18p.; Updated version of the "briefing material" prepared for use by the Congress in considering Public Law 94-437, The Indian Health Care Improvement Act ; Materials prepared in the Office of the President, American Indian School of Medicine
EDRS PRICE	MF-$0.83 HC-$1.67 Plus Postage.
DESCRIPTORS	Accreditation (Institutions); Affiliated Schools; *American Indians; *Development; Facilities; Faculty; Federal Government; Financial Support; Governance; *Higher Education; Historical Reviews; *Medical Schools; *Needs Assessment; Organization; Program Development; *Reservations (Indian); Rural Areas; Students
IDENTIFIERS	*American Indian School of Medicine AZ

ABSTRACT

A compilation of descriptive, factual, and technical information re: the development of the American Indian School of Medicine (AISOM), this document describes the history and current status of AISOM and presents the 1977 projected calendar. AISOM is described as: established by the Navajo Tribal Council in 1977; developing an academic affiliation agreement with Northern Arizona University and the Maricopa County Hospital, the Indian Medical Center and other medical centers in Phoenix, Arizona; and involving a fourth year of education to take place on the Navajo and other Indian reservations in Indian Health Service hospitals and clinics. Employing a question and answer format, this document answers questions relative to the following: Indian health care; Indian doctors; an Indian school of medicine; reservation-based medical education; existing medical schools; Indian support of AISOM; Federal control/intervention; location and facilities; governance and organization; student body; instructional programs; faculty; finances; and accreditation. Also presented are AISOM's financial and personnel projections and documentation of existing Indian support for the development of AISOM. (JC)

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AISOM

THE AMERICAN INDIAN SCHOOL OF MEDICINE

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

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MARCH, 1977

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RC009962

NOTE: This material is an updated version of the "briefing material" prepared for use by the Congress in considering Public Law 94-437, The Indian Health Care Improvement Act. As passed, P.L. 94-437 called for a study to determine the need for and the feasibility of an American Indian School of Medicine. The study is now in process, with reports due to the Secretary of HEW and the Congress in September, 1977.

This document is a compilation of descriptive, factual and technical information regarding the developing American Indian School of Medicine (AISOM).

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HISTORY AND STATUS

Planning and development activities for the establishment of the American Indian School of Medicine (AISOM) were begun by the Navajo Health Authority, by direction of the Navajo Tribal Council, in 1974. It was recognized early that the funding for the AISOM would come partly from the federal government and partly from private sources.

The original plan called for the medical school to be associated with Navajo Community College. However, the accrediting body for medical education--the Joint Liaison Committee on Medical Education of the Association of American Medical Colleges and the American Medical Association--requires that medical schools be affiliated with an accredited four-year college or university. This precluded both association with Navajo Community College and being established as a free-standing medical school. It also precluded the AISOM from being established totally on the Navajo Reservation.

Consideration of alternative approaches and consultation with the AAMC and medical educators led eventually to the assembly of the following approach, which is now in various stages of development:

1. An academic affiliation agreement between Northern Arizona University and the AISOM has been developed and awaits final approval by the Board of Regents of the AISOM.

2. Affiliation with Maricopa County Hospital, Indian Medical Center and other medical centers in Phoenix, Arizona, for third year "clerkship" training. Accreditation requires that this portion of medical education be provided in hospital facilities which have accredited postgraduate medical education programs (medical specialty training programs). Because hospitals in Flagstaff, Arizona, and on the Navajo Reservation do not have such programs, it was necessary to look elsewhere for the development of clinical education capabilities.

3. The fourth year (Senior year) of AISOM medical education will take place on the Navajo and other Indian reservations in Indian Health Service hospitals and clinics, and at the Prescott Veterans Administration Hospital.

The staff of the Navajo Health Authority worked diligently to develop plans, justifications and cost projections, and finally developed proposed legislation to authorize and fund the medical school. Ultimately, for a variety of reasons, the decision was made to include the medical school in the Indian Health Care Improvement Act. This bill would have provided $20 million over a seven-year (7-year) period. With those funds and funds raised through the AISOM Foundation, the American Indian School of Medicine would have been off and running. Because of the possibility of Presidential veto, however, Congress moved to reduce the financial impact of the bill. It (a) reduced the authorization period from seven (7) years

to three (3) years and (b) deleted authorization for funding the American Indian School of Medicine and substituted a one-year study to determine the feasibility and need for an AISOM. That study is now underway and will be completed in mid-1977. In the meantime, the latest Carnegie Commission on Higher Education report has effectively endorsed the need for an AISOM.

In order to maintain the planning momentum and the progress made to date, and assuming a positive feasibility study report, planning and development activities for the AISOM have continued under the sponsorship of the Navajo Health Authority. In January, 1977, the following developments were projected for calendar 1977:

(1) establish AISOM as a legal entity,

(2) secure a Charter;

(3) develop a Plan of Operation;

(4) obtain funding to continue planning and development of AISOM;

(5) receive nominations and seat a pan-Indian Board of Regents;

(6) begin fund-raising activities of the AISOM Foundation; and

(7) keep other Indian tribes and organizations informed of progress and developments.

ON FEBRUARY 24, 1977, THE NAVAJO TRIBAL COUNCIL ESTABLISHED THE AMERICAN INDIAN SCHOOL OF MEDICINE, GRANTED IT A CHARTER, AND ADOPTED ITS PLAN OF OPERATION.

As of March, 1977, needed funding for 1977-1978 has not yet been secured.

The fundamental intent of the planners is--as it has always been--to provide medical education for all American Indians and Alaskan Natives on an equitable basis.

It is generally agreed that the major obstacle to successful start-up of the American Indian School of Medicine is assurance of long-term funding, which is yet another requirement for accreditation. It now appears that this will require specific action on the part of both the Administration and the Congress. We expect this to be forthcoming following presentation of the feasibility study report to the Secretary of HEW and to the Congress in September, 1977.

THE BASIC QUESTIONS

THE MISSION OF THE AISOM IS TO TRAIN AMERICAN INDIANS, ALASKA NATIVES AND OTHER AMERICANS TO BECOME PRIMARY CARE PHYSICIANS WHO WILL PRACTICE ON INDIAN RESERVATIONS AND IN OTHER RURAL, MEDICALLY UNDERSERVED AREAS OF THE UNITED STATES.

A. Indian Health Care

ARE ADEQUATE HEALTH SERVICES AVAILABLE TO AMERICAN INDIANS?

NO. More than half the over one million Native Americans live in rural, remote reservation areas, where their health service is provided by only the Indian Health Service (IHS). While both the quality and the quantity of health care and services to Indians have improved drastically over the past two decades, with funding which has never exceeded 65% of demonstrated need, neither the quality nor the quantity of care is adequate.

HOW IS ACCESS TO CARE?

Reservation Indians still travel long distances, often at great personal expense and sacrifice, with no assurance that they will be able to see a doctor when they arrive. There is no public transportation. These conditions virtually preclude preventive and maintenance care, and result in an inordinate frequency and duration of inpatient care.

HOW IS CONTINUITY OF CARE?

High turnover of physicians and nurses, short-term duty assignments, inability to "schedule" outpatient care, and other factors preclude the "luxury" of ongoing physician/patient relationships.

ARE THERE ENOUGH IHS DOCTORS AND OTHER HEALTH PROFESSIONALS?

No. The chronic shortage of personnel and funds not only affects quality of care, but frequently results in hospital beds and services being closed down.

ARE THE IHS DOCTORS "GOOD" DOCTORS?

Yes. The circumstances make them neither effective nor efficient, however. The turnover rates are high (over 40% per year); about half a two-year "tour of duty" is spent learning to do the job and to communicate with patients who do not speak English; there is a limited understanding or appreciation of religious, cultural, educational and economic constraints and variables which determine patient attitudes and behavior; the system is bureaucratic and cumbersome, and has been frequently described as paternalistic, patronizing and dependency fostering. But the individual doctors themselves are well-trained, dedicated, good doctors who do their best in a most difficult, demanding and frustrating situation.

DO INDIANS ALWAYS UTILIZE THE IHS SYSTEM?

No. Increasing utilization rates are somewhat misleading in that they reflect

improved education, transportation and communication, and not necessarily satisfaction with the system. One study has shown that in one area of the Navajo up to 40% of the Indians purchase their health care off the reservation until their money runs out. Only then do they utilize the free service offered by IHS.

B. Indian Doctors

WHY DO WE NEED INDIAN DOCTORS?

While some argue that it is primarily a maldistribution problem, it is generally agreed that there is a physician manpower shortage in many areas of the United States. Currently, at least 25% of practicing physicians in this country and fully one-third of the hospital house-staff in the United States are foreign medical graduates. (The actual figures are probably higher, for many FMGs are known to be "underground.") American Indians could help meet the shortage now being met by FMGs. Many of the problems of communication and violation of religious and cultural beliefs and preferences could be avoided by Indian physicians treating Indian patients.

HOW MANY INDIAN DOCTORS ARE NEEDED?

It would take over 1,500 new Indian physicians to equal the national physician/population ratio. Depending on the criteria used, there may be as few as 50 or as many as 70 Indian physicians now and 75 to 170 medical students in training. (It has been estimated that as many as one-half the physicians and students who claim to be Indian would not meet the 25% blood quantum criteria of being "Indian.") To date, only one Indian doctor has made a career of medical practice on a reservation.

WHAT COULD INDIAN DOCTORS DO THAT NON-INDIAN DOCTORS CAN'T DO OR DO AS WELL?

Provide positive role models and otherwise provide a significant stimulus to Indian students.
Understand, relate to and communicate with Indian patients.
Provide leadership and facilitate the implementation of Indian self-determination.
Understand and constructively respond to and deal with Indian cultural, social, economic and educational problems, constraints and conflicts.

WON'T YOU STILL HAVE THE PROBLEMS OF TURNOVER, RETENTION AND LIMITED TOUR OF DUTY?

We do not suggest that these problems will be eliminated, but we are certain they will be improved. (More about this later.)

WHY AREN'T THERE ANY MORE INDIAN DOCTORS AND OTHER PROFESSIONALS THAN THERE ARE?

Historically, teachers and others have assumed that professional occupations were neither appropriate for nor obtainable by Indian students. The government-operated educational systems on Indian reservations have not prepared Indian students to compete successfully in colleges and professional schools. Indian students have had to be completely socially and culturally disrupted for 8 to 15 years to complete a medical education.

Indians have been, and are, extremely poor. For example, in 1970 the annual per capita income on the Navajo Reservation was only $753, compared to $3,700 for the United States as a whole.

Finally, there have not been successful Indian professionals to serve as "role models" for Indian students.

C. An Indian School of Medicine?

WHY DO WE NEED AN INDIAN SCHOOL OF MEDICINE?

To allow Indian students to receive a medical education with as little social and cultural disruption as possible; to provide necessary and appropriate support services required by Indian medical students; and to provide opportunity for Indian students who would not otherwise be able to consider becoming physicians. It isn't easy to get into medical schools, even for non-Indians with excellent academic preparation. With the proposed enrollment of the AISOM (eventually 64 per class), plus continuation of the students enrolled in other medical schools, it would still take 20 to 25 years for Indians to achieve the U.S. physician/population ratio.

It has been shown repeatedly that the initiation of higher education programs stimulates and facilitates, both directly and indirectly, the development of better medical care, more and better health programs, and more health manpower training programs. All these are desperately needed.

WHEN IT'S ALL SAID AND DONE, WON'T THIS BE AN INFERIOR PROGRAM WHICH PRODUCES INFERIOR DOCTORS?

Absolutely not. Accreditation and licensing standards and requirements will be the same for the AISOM and its graduates as for any other medical school in the United States. AISOM graduates will be eligible for licensure in any state.

HOW WILL YOU ASSURE THIS "EXCELLENCE"?

- By competitive selection of Indian students from all over the United States.
- By providing continuous, intensive academic, social and personal counseling and support.
- By designing programs in which the success criteria are achievement, knowledge and demonstrated competence, with only the time required to complete the program being variable.
- By designing programs to meet the learning needs of students.
- By minimizing the cultural and social disruption experienced by Indian students in non-Indian schools.

HOW WILL THE AISOM PROGRAMS BE DIFFERENT FROM OTHER SCHOOLS?

- It will train primary care, preventive medicine, family practice oriented physicians.
- It will emphasize those diseases and disease patterns which are unique to Indian people.
- It will emphasize the team approach to health care and health care delivery.

- It will seek to understand and to complement the practice of native medicine.
- It will perform badly needed research on Indian health and disease (which is unique in the United States), and the delivery of health care in rural and reservation settings.
- It will recruit and select students who are committed to practicing medicine on reservations and in other rural, medically deprived areas of the United States, and will design its entire curriculum and programs to promote and assure that result.

D. Reservation-Based Medical Education

WHY DOES CLINICAL EDUCATION HAVE TO BE ON A RESERVATION?

To insure continuing emphasis on and awareness of the health problems of American Indians, and to teach them how to render care in rural and reservation settings.

Indian medical students will better understand and will identify with Indian patients, communities, life styles, philosophies and health practices.

Commitment to Indian people, culture, and communities will be cultivated and strengthened.

Training in the environment in which they are expected to practice will increase the likelihood of graduates practicing on reservations. (Research shows that the majority of physicians go into practice within a 250-mile radius of where they complete their training.)

To stimulate improved health care delivery on reservations.

To enhance the understanding and development of skills in accommodating traditional religious and cultural aspects of illness and health with scientific medicine.

To encourage and facilitate the collection of relevant health data and the performance of needed research regarding Indian health and disease.

To minimize costs by utilizing existing IHS and other facilities, and by utilizing qualified IHS staff as faculty on a part-time basis.

E. Existing Medical Schools

CAN'T YOU USE EXISTING MEDICAL SCHOOLS AND ACHIEVE THE SAME RESULT?

YES, we could use existing schools.
NO, we could not achieve the same results.

Existing medical schools and medical school faculty are neither organized nor philosophically oriented to cope with the cultural, social and religious conflicts Indian students encounter in Western medical education.

There is evidence that the legislative, legal, and provincial constraints imposed

on many medical schools will not allow continuation of the present "concessions" of schools to admit Indian and other minority students.

Minority student programs in existing schools are expensive, as they require special attention, take extra time and effort and require other "exceptions" in order to be successful.

The "De Funis syndrome" (i.e., the problem professional schools encounter when they accept lesser qualified minority students instead of a better qualified Anglo student).

Recruitment, selection, admission, and teaching policies and procedures in existing medical schools do not adequately address the issues of:

- the capable student who has not had sufficient or adequate secondary and postsecondary preparation;
- the economically disadvantaged student;
- the student whose culture and/or religious beliefs are in conflict with the Anglo culture and system he must cope with in medical school; and
- the need for individualized, ongoing counseling and support services for Indian students.

WHAT WILL AISOM DO?

AISOM will prepare its graduates for the practice of primary medical care where the need of the American Indian community lies. Other medical schools expect and strongly promote specialization and dependence on sophisticated, urban medical facilities, thereby "training physicians away from" rural medicine. It has been said that "Students emulate their professors, and professors tend to replicate themselves." It is the AISOM's intention to take advantage of this phenomenon.

F. Indian Support of AISOM

IS THE AISOM SUPPORTED BY ALL INDIANS?

There are over 1,100,000 Indians, and over 300 federally recognized Indian tribes. Not surprisingly, not all believe an AISOM is possible, or even that it is a good idea. The major Tribes, tribal Associations, Regional and National Indian Organizations have strongly endorsed the AISOM, however. A listing of major supporting Indian organizations appears as a supplement to this document.

IS THERE EVIDENCE THAT WE REALLY NEED AN AISOM?

The "Richardson Feasibility Study" (1972) determined there was a need and that such a school is feasible. The planning and development work of the Navajo Health Authority confirms that judgment. The Carnegie Commission on Higher Education (1976) effectively endorsed the concept of an AISOM.

P.L. 94-437 authorized a study to determine the need for and feasibility of an AISOM. The report is to be presented to the Secretary of HEW and to the Congress by September, 1977.

G. Imponderables

IS THE AISOM THE ANSWER TO THE MANY PROBLEMS OF INDIAN HEALTH AND HEALTH CARE DELIVERY?

Realistically, neither this nor any other single program is "the answer." We know that the present system and programs are inadequate to the need, however, and are convinced that the AISOM will precipitate many improvements as it works in cooperation with the IHS.

DOES FEDERAL SUPPORT INVITE FEDERAL INTERVENTION AND CONTROL OVER AISOM?

Yes, but to no greater extent than for other American medical schools, all of which receive over half their financial support from federal sources. One requirement for accreditation is an independent board of directors who are not controlled by any outside body, and who have complete responsibility for governance of the school.

HOW WILL YOU MINIMIZE THE PROBLEM OF FEDERAL CONTROL/INTERVENTION?

- By having an independent Board of Regents.
- By having regular, periodic review and public comment and disclosure by the Association of American Medical Colleges (AAMC), the American Medical Association (AMA), the Association of American Indian Physicians (AAIP), the Association of Native American Medical Students (ANAMS), and other professional and national groups and organizations.

TECHNICAL INFORMATION

The AISOM was conceived by the Navajo Tribal Council in 1972 in response to the anticipated decline in the availability of doctors due to termination of the military draft. The Council established the Navajo Health Authority in 1972, and commissioned it to:

1. Improve the health care system on the Navajo Reservation; and
2. Establish an American Indian School of Medicine to serve all Indian people.

The NHA has been planning and working toward the development of the AISOM since 1974, under the guidance and direction of Taylor McKenzie, M.D., the first Navajo Physician. Dr. McKenzie first served as Chairman of NHA's governing board, then as Executive Director of the Navajo Health Authority, and since 1974 as Dean (now President) of the proposed school.

The following questions represent the current status and development of the AISOM planning efforts to date.

A. Location and Facilities

The President's Office, one of the Clinical Training facilities, and the post-graduate Family Practice Residency Program are to be at Shiprock, New Mexico, where the

Administration and Library Building and the Family Health Center Building have been provided by the Navajo Tribe. Clinical training will take place in the Shiprock IHS Hospital and in other IHS clinical facilities on the Navajo and on other Indian reservations throughout Indian Country.

Affiliation agreements are under development with the Arizona Board of Regents (for NAU), the Veterans Administration (for use of clinical facilities at Prescott, Arizona), the Maricopa County Health System (for Clerkship training at Phoenix), and with the Indian Health Service (for use of IHS clinical facilities). Others will be developed as needed.

WHY SHIPROCK, ON THE NAVAJO RESERVATION?

The Navajo people and the Navajo Tribal Council have taken the initiative to start the school and have supported its planning and development, including provision of buildings valued at over $1 million.

The Navajo is the largest reservation, and the Navajo tribe represents the largest concentration of Indian people in the United States. (There were approximately 140,000 Navajos on the Navajo Reservation in 1970. Projected Navajo population in 2000, at the present birthrate, is 384,000.)

Shiprock is the largest service unit in the IHS system, serving a population of approximately 30,000.

WHY WAS NORTHERN ARIZONA UNIVERSITY AT FLAGSTAFF SELECTED FOR ACADEMIC AFFILIATION?

Accreditation as a medical school requires affiliation with a fully accredited, four-year university. NAU is the closest such facility to the Navajo Reservation.

NAU already has programs in Nursing and the Allied Health Sciences.

NAU has a history of promoting and assisting the attendance of Indian students, and presently has the largest enrollment of Indians of any university in the United States.

Within a 500-mile radius of Flagstaff, Arizona, over half the Indian population of the U.S. reside in their own cultural environment.

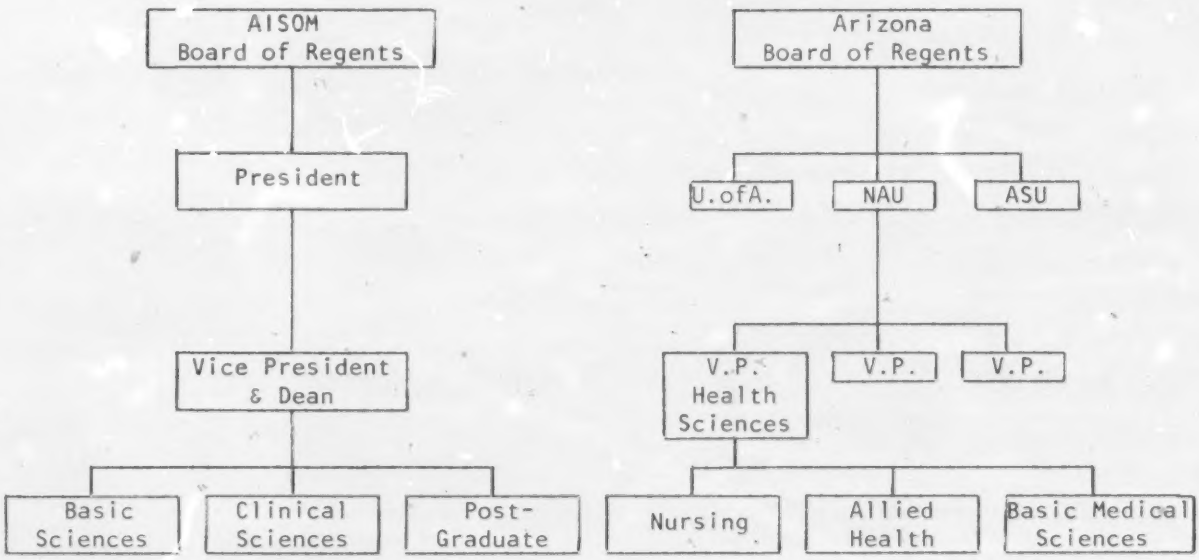
The Flagstaff community has demonstrated strong support for the school, possibly including making available the land and buildings needed by the AISOM.

B. Governance and Organization

WHO WILL CONTROL AND GOVERN THE AISOM?

A governing board of not fewer than six (6) nor more than thirteen (13), the majority of whom are Indian.

Organizational Relationships



C. Student Body

WHERE WILL STUDENTS COME FROM?

Students will be recruited from all Indian tribes and organizations. Admission will be limited to well-qualified students who are committed to practice on Indian reservations and in other rural, medically deprived areas.

WILL THE STUDENT BODY BE ALL INDIAN?

No. It is anticipated that about 20% will be non-Indian.

ARE THERE ENOUGH QUALIFIED INDIAN STUDENTS AVAILABLE?

In 1975, 543 Indian students took the Medical School Admissions Test (MCAT). Of those, 140 received qualifying scores compatible with success in the medical curriculum. Only 70 were admitted to medical schools, leaving a pool of approximately 70 qualified candidates who did not receive admission. Preliminary surveys also show a substantial number of present students who would transfer to AISOM if it were now operating.

WILL INDIAN MEDICAL STUDENTS DIFFER IN ANY SUBSTANTIAL WAY FROM OTHER MEDICAL STUDENTS?

Yes. It has been shown that the typical Indian medical student is older, is married and has children, and that he tends to require counseling, tutoring and other support services more often than non-Indian students. We have already noted the cultural and religious constraints and conflicts.

D. Instructional Programs

HOW WILL AISOM INSTRUCTION AND PROGRAMS DIFFER FROM THOSE OF OTHER MEDICAL SCHOOLS?

- AISOM will provide professional counseling and other support services on a continuous basis.
- AISOM will emphasize primary, preventive, family oriented health/medical care.
- AISOM will emphasize unique Indian (and rural) disease and other health problems.
- AISOM will develop and emphasize complementary and supportive relationships with practitioners of the Native healing sciences.
- AISOM will develop training programs which are responsive to the cultural constraints, limitations and requirements of American Indian students.

E. Faculty

WILL THE AISOM FACULTY BE EXCLUSIVELY OR PREDOMINANTLY INDIAN?

Initially, because of the small number of Indian physicians and other health professionals, the faculty will be primarily non-Indian. A goal of the AISOM is to recruit and develop Indian professionals and to eventually have a predominantly Indian faculty and administration. The primary and major criteria for faculty, however, is "excellence" and commitment to the goals of the AISOM.

ARE ANY FACULTY HIRED YET?

Taylor McKenzie, M.D. (Navajo), is serving as the President of the AISOM (located at Shiprock, New Mexico).

Jasper L. McPhail, M.D. (Anglo), is serving as the Vice President and Dean (located at Phoenix, Arizona).

ARE THERE SUFFICIENT QUALIFIED AND AVAILABLE FACULTY FOR THE AISOM?

Yes. We have, and continue to receive expressions of interest in the AISOM from highly qualified physicians and other health care professionals. We will be working hard to improve the ratio of Indians to non-Indians as more Indian students complete professional education in the various health professions, including medicine.

F. Finances

WHAT ARE THE "START-UP COSTS" OF THE AISOM?

For the typical medical school start-up costs include from $30 to $150 million in construction costs. Since the AISOM will use existing educational and clinical facilities, there will be no immediate capital construction costs. Within a few years we will have to construct a basic science building and some housing for students, faculty and staff in Shiprock, at an estimated total cost of $10,000,000.

WHAT ARE THE PROJECTED OPERATING COSTS?

The projected operating budget for the first fiscal year the AISOM has students (now planned for 1979-80) is approximately $2.5 million. The projected annual budget when in full operation (in approximately 5 years) is approximately $5.5 million. Cost and budget projections are being updated periodically.

ARE THESE COSTS COMPARABLE TO OTHER MEDICAL SCHOOLS?

Yes. Even though certain costs (transportation, travel, certain support personnel) will be higher than in some medical schools, this will be offset by fewer resources being committed to the maintenance of a large physical plant, "basic medical research", and to ultra-specialization, all of which are very expensive.

HOW ABOUT RESIDENCY AND OTHER POST-GRADUATE PROGRAMS?

Because emphasis will be on the training of primary care, family practice oriented physicians, and because AISOM will utilize existing facilities and training programs, the cost of expensive post-graduate training programs will be minimized. The Family Practice Residency Program is already under way in Shiprock, New Mexico.

HOW MUCH OF THE AISOM OPERATING FUNDS WILL COME FROM THE FEDERAL GOVERNMENT?

Current estimates of the proportion of Federal "subsidy" of medical education programs range from 50% to 70% of the total cost (same as for other medical schools).

WILL YOU REQUIRE ADDITIONAL FUNDS AND WHERE WILL THEY COME FROM?

Yes. They will come from Indian tribes, foundations, public donations and tuition, as well as other grants and contracts.

WHAT IS THE AISOM FOUNDATION?

The AISOM Foundation was incorporated in August, 1975. The Foundation's purpose is to assist in securing funds to support the AISOM and other Indian health/medical training programs.

G. Accreditation

REALISTICALLY, WHAT ARE THE PROSPECTS FOR ACCREDITATION OF THE AISOM?

The Liaison Committee on Medical Education (LCME) of the AAMC and the AMA made their first consultative visit in January, 1973. Their second visit was on October 1 and 2, 1975. These visits, combined with the consultation and advice of the Dean's Medical School Planning Committee (a group of medical educators chaired by the eminent William A. Sodeman, Sr., M.D.), continue to keep the development of AISOM focused on the essential requirements for accreditation.

There are many requirements which must be met to obtain accreditation, without which the school could neither begin operation nor continue to function after it is in operation. These requirements include:

1. Long-range financial support for the school.
2. An independent and competent governing body.
3. An assured "pathway to the M.D. degree", which means firm arrangements which guarantee that a student will have the opportunity to complete the entire curriculum without interruption.
4. Competent and adequate numbers of faculty, representing all needed disciplines.
5. A fully competent and well-organized administrative and business support organization.
6. Adequate physical facilities.
7. Affiliation with an accredited, four-year university.
8. Adequate justification for the program.
9. Evidence of constituent and professional support for the program.
10. A qualified pool of available students.
11. Plans for student guidance and academic counseling.
12. A proposed plan of the curriculum.
13. Plans for evaluation of the program.
14. A complete development plan for the school.

The key ingredient is No. 1. The AISOM must have assurance of adequate financial support for at least 20 years of operation. Given this, the other requirements can be met.

A.

AISOM
FINANCIAL PROJECTION*

Year	Number of Students	Projected Budget
1977-1978	0	$ 400,000
1978-1979	0	900,000
1979-1980	64	2,330,000
1980-1981	160	3,635,000
1981-1982	256	4,522,000
1982-1983	288	4,729,000
1983-1984	320	5,010,000
1984-1985	320	5,260,000
1985-1986	320	5,500,000

*This projection assumes the LCME will give permission to admit a class of 32 Freshmen and 32 second-year students in 1979.

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POSSIBLE SOURCES OF FUNDS, SELECTED YEARS

	1977	1978	1979	1980	1981	1984
Federal Appropriation	$ -	$ -	$1,200,000	$1,575,000	$1,996,000	$3,080,000
Capitation	-	-	128,000	320,000	512,000	640,000
Other Federal Assistance	300,000	640,000	480,000	800,000	640,000	-
Tuition	-	-	256,000	640,000	1,024,000	1,280,000
Indian Tribes & Organizations	100,000	250,000	250,000	250,000	250,000	250,000
AISOM Foundation**	-	10,000	16,000	50,000	100,000	250,000
Total	$400,000	$900,000	$2,330,000	$3,635,000	$4,522,000	$5,500,000

**Note that the AISOM Foundation will have to provide substantial support both in the early years and after capitation and other Federal assistance is terminated.

B.

SUPPORT DOCUMENTS ON HAND
FOR THE
AMERICAN INDIAN SCHOOL OF MEDICINE

as of January 1976

NATIONAL

National Indian Health Board, Inc.	March	1973
Association of American Indian Physicians	August	1974
National Congress of American Indians	October	1974
Seven States Indian Health Association	October	1974
United Southeastern Tribes	November	1974
National Tribal Chairmen's Association	January	1975
Amer. Ind. Com. on Alcoholism & Drug Abuse	January	1975
National Indian Education Association	September	1975
Association of Native American Health Professionals	October	1975

REGIONAL

Sisseton Wahpeton Sioux Tribe	September	1974
California Rural Indian Health Board	January	1975
Phoenix Area Health Board	January	1975
Oklahoma Area (IHS) Advisory Board, Inc.	February	1975
All-Indian Pueblo Council	May	1975
Sells Executive Health Board	May	1975
Inter-Tribal Council of Nevada	May	1975
Bristol Bay Area Health Corporation (Alaska)	December	1975

LOCAL

The Navajo Tribal Council	June	1971
Shiprock District Council	July	1973
Two Grey Hills Chapter	August	1973
Kayenta Service Unit Health Board	November	1973
Tuba City Agency Council	November	1973
Shiprock Service Unit Health Board	May	1974
Navajo Area School Board Association	June	1974
Reservation-Wide CAC Executive Board	June	1974
Reservation-Wide School Board Conference	June	1974
Shiprock Chapter	October	1974
Tuba City Chapter	January	1975
Tuba City Service Unit Health Board	January	1975
Coppermine Chapter	January	1975
Navajo Area Indian Health Board	February	1975
Rough Rock School Board, Inc.	February	1975
Chilchinbeto Chapter	March	1975
Fort Defiance Agency Council	April	1975
Fort Defiance Service Unit Health Board	April	1975
Tuba City DNA Agency Council	April	1975
Canoncito Chapter	April	1975
Navajo Nation Health Foundation	May	1975